Figure 2-20-N-5 Data Flow Charts

A. TRICARE Senior Option - Enrollment Data Flow

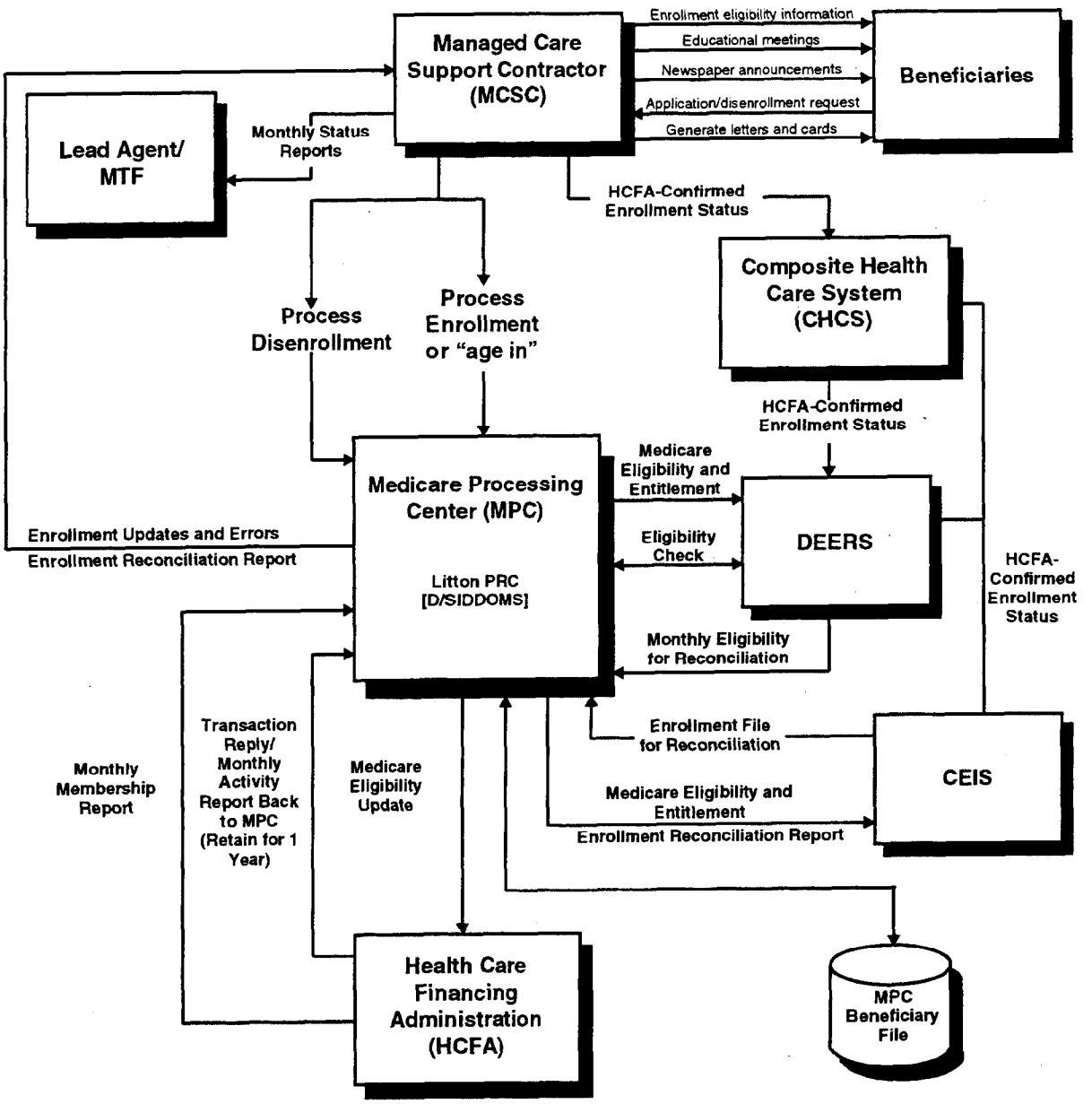

Figure 2-20-N-5 Data Flow Charts (Continued)

B. TRICARE Senior Option - Claims/Clinical Data Flow

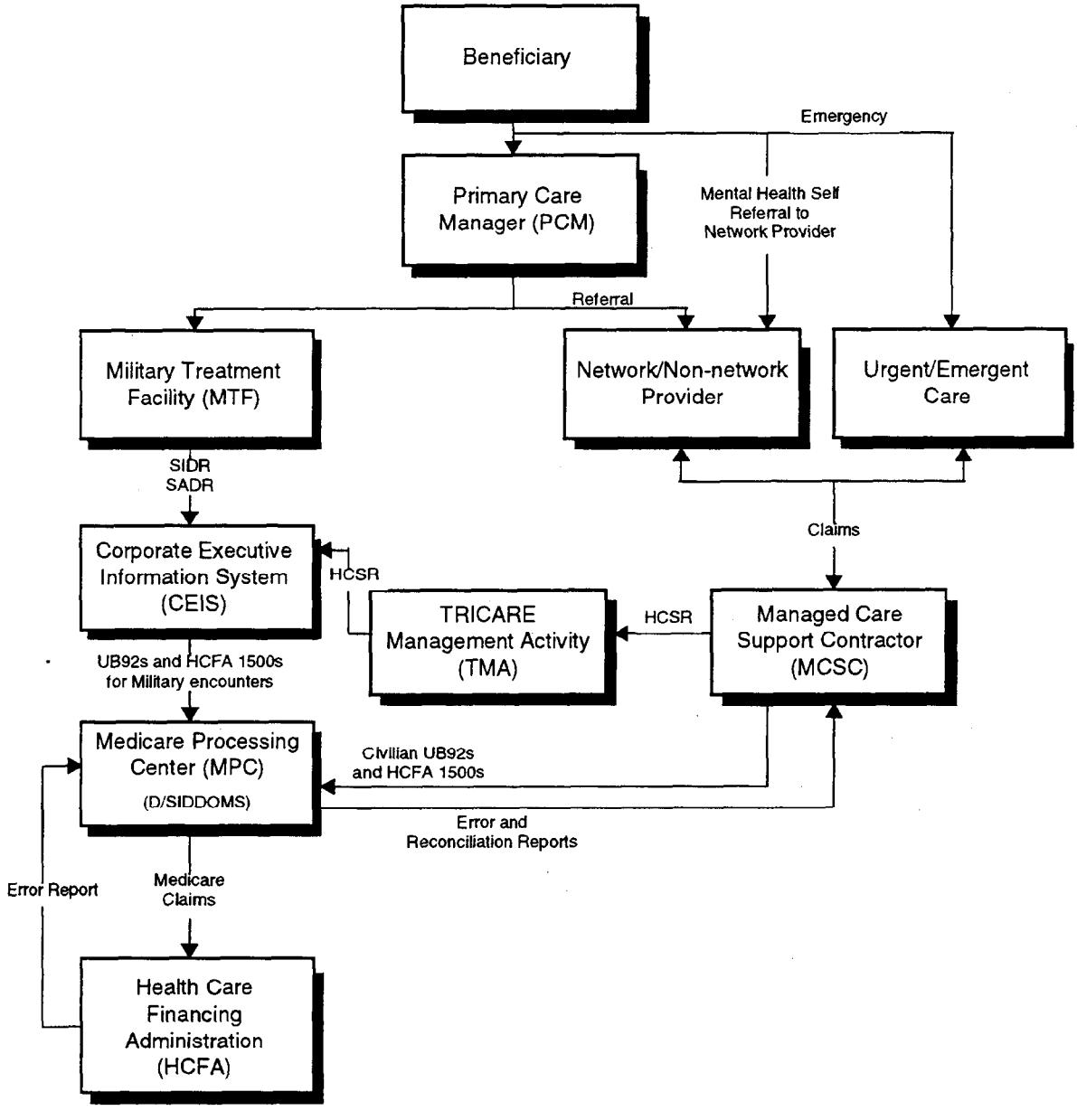

Figure 2-20-N-6 Disenrollment

Involuntary Disenrollment

In all cases of involuntary disenrollment, the enrollee has twenty-nine (29) days from the date of receipt to respond to the Notice of Intent to be Involuntarily Disenrolled. Medicare permits involuntary disenrollment of an enrollee in *an M+C Organization* following appropriate due process. Under the TRICARE Senior Prime program, the MTF Commander may apply the Medicare procedures for involuntary disenrollment. The MTF Commander may not propose to terminate an enrollee based upon his/her utilization of services or mental illness unless it has a direct effect upon the ability to deliver services. The MTF Commander may not initiate disenrollment because the beneficiary exercises his/her option to make treatment decisions with which the MTF disagrees; e.g., refuses aggressive treatment for cancer.

A beneficiary may be involuntarily disenrolled for the following reasons:

1. Enrollee moves out of the *M+C Organization's* geographic area. Upon direction of the MTF Commander/Lead Agent, the *M+C Organization* will disenroll a Medicare enrollee who moves out of its geographic area and does not voluntarily disenroll if the *M+C Organization* establishes, on the basis of a written statement from the enrollee or other evidence acceptable to HCFA, that the enrollee has permanently moved out of its geographic area. Upon approval of the MTF Commander, the contractor must give the beneficiary a written notice of termination of enrollment. The notice must be mailed to the enrollee prior to the submission of the disenrollment notice to HCFA. The notice to the beneficiary must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established under HCFA regulations 42 CFR §417.436.

2. Enrollee commits fraud or permits abuse of *M+C Organization* enrollment card. A Medicare beneficiary may be disenrolled by the *M+C Organization* if the beneficiary knowingly provides, on the application form, fraudulent information upon which an *M+C Organization* relies and which materially affects his or her eligibility to enroll in the *M+C Organization*, or if the beneficiary intentionally permits others to use his or her enrollment card to receive services from the *M+C Organization*. In either case, the *M+C Organization* must give the beneficiary a written notice of termination of enrollment. The notice must be mailed to the enrollee prior to the submission of the disenrollment notice to HCFA. The notice must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established under HCFA regulations 42 CFR §417.564.

3. Enrollee's entitlement to benefits under the supplementary medical insurance program ends. HCFA's liability for monthly capitation payments to the *M+C Organization* on behalf of the beneficiary ends with the month immediately following the last month of entitlement to benefits under Part B of Medicare.

(a) *The M+C Organization must provide the enrollee a written notice of disenrollment if the individual loses entitlement to Part A or Part B benefits. HCFA will notify the M+C Organization that the disenrollment is effective the first day of the calendar month following the last month of entitlement to Part A or Part B benefits. (422.74)*

Figure 2-20-N-6 Disenrollment (Continued)

4. Disenrollment for cause. An *M+C Organization* may disenroll a Medicare enrollee for cause if the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing enrollment in the *M+C Organization* seriously impairs the *M+C Organization's* ability to furnish services to either the particular enrollee or other enrollees.

(a) Effort to resolve the problem. The *M+C Organization* must make a serious effort to resolve the problem presented by the enrollee, including the use (or attempted use) of internal grievance procedures.

(b) Consideration of extenuating circumstances. The *M+C Organization* must ascertain that the enrollee's behavior is not related to the use of medical services or *due to diminished mental capacity.*

(c) Documentation. The *M+C Organization* must document the *enrollee's behavior, its efforts to resolve problems and any extenuating circumstances. (422.74(d)(2))*

(d) HCFA decides based on a review of the documentation submitted by the *M+C Organization*, whether disenrollment requirements have been met. HCFA makes this decision within *20* working days of receipt of the documentation material, and notifies the *M+C Organization* within 5 working days after making its decision.

(e) Effective date of disenrollment. If HCFA permits an *M+C Organization* to disenroll an enrollee for *disruptive behavior*, the disenrollment takes effect on the first day of the calendar month after the month in which the *M+C Organization* complies with the notice requirements. *(422.74(c))*

Before beginning the disenrollment for cause process, the MTF Commander will make a serious effort to resolve the problem presented by the enrollee and inform the enrollee that his/her continued behavior may result in termination of membership in TRICARE Senior Prime. If the problem cannot be resolved, the MTF Commander will give the member written notice of intent to request disenrollment for cause. In this notice, the MTF Commander will include an explanation of the enrollee's rights to a hearing under the organization's grievance procedures.

Proposed Disenrollment Notice

Once the grievance process has been completed or the member has chosen not to use this process, the MTF Commander will provide documentation to HCFA for involuntary disenrollment of the enrollee. Documentation will include:

(1) The reason that the MTF is requesting disenrollment for cause.

(2) A summary of efforts to explain the issues to the enrollee and the other types of options presented before disenrollment was considered.

(3) A description of the enrollee's age, diagnosis, mental status, functional status, and social support system; and

Figure 2-20-N-6 Disenrollment (Continued)

(4) Separate statements from primary providers describing their experience with the enrollee.

Voluntary Disenrollment

A Medicare enrollee may disenroll at any time by giving the *M+C Organization* a signed, dated request in the form and manner prescribed by the *M+C Organization*. The enrollee may request a certain disenrollment date but it may be no earlier than the first day of the month following the month in which the *M+C Organization* receives the request. The *M+C Organization* must submit a disenrollment notice to HCFA promptly.

An *M+C Organization* must provide the enrollee with a copy of the written request for disenrollment. Risk *M+C Organizations* must also provide a written statement explaining that the enrollee remains enrolled in the *M+C Organization* until the effective date of the disenrollment.

Figure 2-20-N-7 Manual Manipulation of the Spine - Medicare Coverage

Operational Policy Question:

Which practitioners are authorized by law to perform manual manipulation of the spine as a Medicare covered service?

Answer:

Section 1861(r) of the Social Security Act provides the definition of a physician for Medicare coverage purposes, which includes a chiropractor for treatment of manual manipulation of the spine to correct a subluxation demonstrated by x-ray. The statute specifically references manual manipulation of the spine to correct a subluxation demonstrated by x-ray as a physician service. Thus, managed care plans may use physicians to perform this service.

Managed care plans contracting with Medicare are not required, however, to offer services of chiropractors, but may use other physicians to perform this service. In addition, managed care plans may offer manual manipulation of the spine as performed by non-physician practitioners, such as physical therapists, if allowed under applicable state law.

Please also note that section 2153.1 of the Medicare HMO/CMP manual states that marketing materials of managed care plans must clearly state which physician specialties are authorized by the plan to provide manual manipulation of the spine.

Figure 2-20-N-8 *M+C Organization* 2104. Emergency Services

Assure that medically necessary emergency care is available 24 hours a day, 7 days a week. Beneficiaries are not required to receive emergency services at your plan facilities nor are they required to secure prior approval for emergency services provided inside or outside your geographic area. Provide a system to pay claims for emergency services provided out-of-plan and pay for all emergency services provided out-of-plan. (See 2107 for the permissible limits on the amount you must pay.)

2104.1 Definition.--Use the definition provided in 42 CFR *422.2*. Specifically, "emergency services" mean covered inpatient and outpatient services that are:

- Furnished by *a provider qualified to furnish emergency services; and*
- Needed *to evaluate or stabilize an emergency medical condition,*

EXAMPLE: While visiting her son, a 70 year old woman with a history of cardiac arrhythmias experiences a rapid onset of chest pain, nonproductive hacky cough, and generalized tired feeling. The son calls his own physician, who recommends he bring his mother in to see him right away. After the physician evaluates the patient, the physician diagnosis is a common cold, and he prescribes two over-the-counter medications for treatment.

In this case, the *M+C Organization* is required to pay for the physician's services because the enrollee's medical condition appeared to require immediate medical services.

There does not need to be a threat to a patient's life. An emergency is determined at the time a service is delivered. Do not require prior authorization. You may request notification within 48 hours of an emergency admission or as soon thereafter as medically reasonable. However, payment may not be denied if notification is not received.

If it is clearly a case of routine illness where the patient's medical condition never was, or never appeared to be, an emergency as defined above, then you are not responsible for payment of claims for the services. Do not retroactively deny a claim because a condition, which appeared to be an emergency, turns out to be non-emergency in nature.

All procedures performed during evaluation and treatment of an emergency condition related to the care of that condition must be covered. An example is a member who is treated in an emergency room for chest pain and the attending physician orders diagnostic pulmonary angiography as part of the evaluation. Upon retrospective review, you cannot decide that the angiography was unnecessary and refuse to cover this service.

If during treatment for an emergency situation, the enrollee receives care for an unrelated problem, you are not responsible for the care provided for this unrelated non-emergency problem. An example is a member who is treated for a fracture and the attending physician also treats a skin lesion. You are not responsible for any costs, such as a biopsy, associated with treatment of this unrelated non-emergency care.

After the emergency, pay the cost of medically necessary follow-up care. (See HMO Manual Section 2105.)

Figure 2-20-N-8 *M+C Organization* 2104. Emergency Services (Continued)

2104.2 Transfers.--If one of your Medicare enrollees receives emergency medical care in a non-plan hospital, you may wish to transfer the patient to your facility (or a facility that you designate) as soon as possible. Pay the transfer costs, such as an ambulance charge, if it is necessary.

Be aware that the transferring hospital is subject to statutory limitations on when, and how, the transfer may be made. Under Section 1876 of the Act, the hospital must first determine whether the patient's condition has stabilized within the meaning of the statute. In general, this means that within reasonable medical probability, no material deterioration of the condition is likely to result from, or occur during, the transfer

If the patient's condition has not stabilized, the patient may only be transferred if the patient makes an informed, written request for transfer, or the attending physician or appropriate medical authority signs a certification that the risks of the transfer are outweighed by the medical benefits expected from transfer to another medical facility. If these conditions are met, then the transfer may be made, but only if it also meets the definition of an appropriate transfer. (See Section 1876(c)(2) of the Social Security Act.)

In general terms, an appropriate transfer is one in which:

- The transferring hospital:
  1. Provides medical treatment to minimize the risks to the individual,
  2. Forwards all relevant medical records, and
  3. Uses qualified personnel and transportation equipment for the transfer;
- The receiving facility:
  1. Has available space and qualified personnel, and
  2. Except for specialized facilities that under Section 1876(g) of the Act cannot refuse a transfer, agrees to accept the transfer and provide appropriate medical treatment: and
  3. The transfer meets any other requirements the Secretary may find necessary in the interest of health and safety of individuals.

If the transferring hospital fails to meet these requirements, it may lose its Medicare provider agreement or be subject to civil money penalties or a civil action for damages. Physicians involved in an improper transfer may also be subject to civil money penalties and may be excluded from participation in Medicare.

Provide assistance with the above requirements to facilitate an appropriate transfer to one of your facilities or a facility that you designate.

If there is a disagreement over the stability of the patient for transfer to another inpatient facility, the judgment of the attending physician at the transferring facility prevails and is binding on the *M+C Organization*.

Figure 2-20-N-8 *M+C Organization* 2104. Emergency Services (Continued)

HMO 2105. URGENTLY NEEDED SERVICES

Use the definition provided in 42 CFR 422.2. Specifically, urgently needed services are covered services provided when an enrollee is temporarily absent from the TSP service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the TSP provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it was not reasonable given the circumstances to obtain the services through TSP.

Cover these services if:

- The enrollee is temporarily absent from your geographic area, and
- The receipt of health care services cannot be delayed until the enrollee returns to your organization's geographic area. The enrollee is not required to return to the service area because of the urgently needed services.

Urgently needed care pertains only to out-of-area care to treat an unforeseen condition. Prior authorization is not needed in seeking urgently needed services. Your marketing materials must clearly describe the concept of urgently needed services as well as include an explanation of the enrollee's rights in these situations.

EXAMPLE: A 72 year old man had a left femoral bypass graft 6 weeks ago. He goes on his previously scheduled vacation to his sister's house who lives out of the service area. While there, he begins to notice left leg numbness that is occurring with greater frequency and intensity and is not totally relieved by his medications. His sister takes him to see her physician.

Pay for the physician's services because the enrollee's medical condition appeared to be such that the provision of medical services could not be delayed until the enrollee returned to your service area.

Services that can be foreseen are not considered urgently needed services, and without *a* prior authorization *the plan is not required to pay for these services.* For example, you are not required to pay without prior authorization when a member who needs oxygen therapy travels outside your service area for a personal emergency or a vacation. Develop a clear policy on your responsibility and the beneficiary's financial responsibility in these situations. Consider making special arrangements with providers outside your service area or clearly discussing any restrictions on out-of-area coverage with Medicare beneficiaries at the time of application.

Figure 2-20-N-8 *M+C Organization* 2104. Emergency Services (Continued)

Marketing materials must clearly describe the limits of your out-of-area coverage. Assume responsibility for urgently needed services without regard to the length of absence from the geographic area, as long as the enrollee maintains membership in your plan. However, if the enrollee is absent for an extended period (beyond *12* consecutive *months*) and you have not been notified and have not arranged for membership to continue, you may assume that the move is a permanent move and begin procedures to disenroll the beneficiary. If you do not disenroll the beneficiary and you know that he/she is absent for *up to 12 months*, then you are liable for all services rendered, including routine care. (See HMO Manual Section 2001ff.)

Cover medically necessary follow-up care to emergency and urgent care situations if that care cannot be delayed without adverse medical effects.

Figure 2-20-N-9 *M+C Organization* Peer Review Organization Relationship

Assumption of Review: The PRO is to notify all *M+C Organizations* in its service area of its assumption of review. This notice is to be sent within five (5) working days of the later of the effective date of its *M+C Organization* review contract or the date HCFA notifies the PRO of the participation of a risk *M+C Organization*.

The PRO is to comply with all requirements concerning relationships with *M+C Organizations*, hospitals and other facilities and providers specified in regulation.

Memorandum of Understanding: Each PRO is to modify or execute written agreements (pertaining to review of risk *M+C Organization* care) acceptable to HCFA with the Medicare risk *M+C Organizations* in its area no later than 45 days after the later of its *M+C Organization* review contract effective date or HCFA notification as specified above. The PRO is to notify its project officer if any *M+C Organization* fails to sign an MOU within 45 days.

The agreement is to identify appropriate contact persons for all required activities (i.e., certification of the list of users/nonusers, certification of the targeted review data, receiving medical records on a flow basis, etc.) and contain the following:

- The party responsible, i.e., the hospital or *M+C Organization*, for distributing the "Important Message" to enrollees;
- Notification procedures for when an *M+C Organization* clinic, or other provider, closes and reopens under a different provider name;
- The *M+C Organization* giving the PRO copies of all policies, protocols, specific to a potential quality concern or a specific area, lists of covered services, lists of participating providers, and quality assurance plans, and providing copies of updates to these on a quarterly basis;
- The selection of all required samples;
- *M+C Organization's* responsibility to identify and provide ambulatory and other medical records pertaining to all risk *M+C Organization* care rendered through the termination date of the *M+C Organization* contract.
- The PRO's right to request records for additional care outside of the standard review period whenever the PRO review suggests the need to investigate possible quality concerns.
- Timing and location of PRO review;
- Procedures for obtaining records or copies of records for review (e.g., photocopying) and the amount the PRO is to pay for photocopying and mailing records;
- Cooperation by the PRO with the *M+C Organization* and physicians/providers prior to issuing a final quality of care decision;
- Focused review requirements:

Figure 2-20-N-9 *M+C Organization* Peer Review Organization Relationship (Continued)

- Requirements for the *M+C Organization* to provide records, when necessary to the PRO for Super PRO review.
- Provisions for the modification of the agreement by either of the parties and for notification to the HCFA Regional Office of such modifications.

Where a potential quality concern exists, the PRO is to provide the *M+C Organization* (and the provider or physician) with an opportunity to discuss the proposed decision. The PRO should specify in its agreement with the *M+C Organization* which *M+C Organization* parties are to have authority to discuss the proposed quality concerns.

The PRO is to be evaluated on its success coordinating and cooperating with the *M+C Organization* and related physicians/provides in order to assure or improve the quality of care provided the Medicare beneficially.

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)*

HMO 2402. WRITTEN EXPLANATION OF APPEALS PROCEDURES

Inform all enrollees in writing of the appeals procedures. Provide members with written descriptions in the following situations:

- *Every time a service or payment is denied (42 CFR 422.568(d)(3))*
- At initial enrollment as part of the membership materials;
- Each year in the annual rights notice; and
- Upon request by the enrollee or his/her representative.

Clearly distinguish between grievance issues and appeal issues in all written explanations. Describe all steps of the Medicare appeals *procedures*, from the *organization* determination by the health plan to the judicial review rights after exhaustion of administrative appeal rights. Include time limits, amount in controversy requirements and procedures for filing appeals.

In all adverse *organization* determination notices, include *a description of* the member's right to a reconsideration *as well as a description of the rest of the appeal process. (42 CFR 422.568(d)(3))*

HMO 2403. *ORGANIZATION* DETERMINATIONS

An *organization* determination is defined at 42 CFR *422.566(b)* as *any* determination *made by an M+C organization with respect to any of the* following:

- *Payment* for emergency *services, post stabilization care* or urgently needed services;
- *Payment for any other services furnished by a provider or supplier other than the organization that the enrollee believes are Medicare covered or should have been furnished, arranged for or reimbursed by the organization; or*
- The organization's refusal to provide services the enrollee believes the organization is obligated to cover, and the enrollee has not obtained them elsewhere.
- *Discontinuation of a service.*

Issue a written notice for all *adverse organization* determinations. Resolve all disputes involving *organization* determinations through the appeal procedures.

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

2403.1 Time Limit for Issuing an *Organization* Determination Notice.--Issue *organization* determination notices for all "clean" claims within 24 calendar days of receiving the claim. A "clean" claim has no defect, impropriety or particular circumstance requiring special treatment preventing timely payment. Claims that lack any required documentation or authorization numbers are not considered clean.

For non-"clean" claims, issue an *organization* determination notice to the member within 60 calendar days of receiving the request for payment or services. Send *organization* determination notices for transferred claims to the member within 60 calendar days of the receipt of the claim from the carrier or intermediary. Do not delay the determination past 60 days, even to wait for medical records or additional information. Failure to issue a written notice within 60 days of your claim constitutes an adverse *organization* determination, which the member may appeal.

The M+C organization must pay interest on clean claims that are not paid within 30 days in accordance with section 1816(c)(2)(B) and 1842(c)(2)(b). All other claims must be approved or denied within 60 calendar days from the date of the request.

2403.2 Required *Organization* Determination Notice.--Issue an *organization* determination notice when a member requests payment or services as described below:

1. **Reimbursement for Emergency or Urgently Needed Services.**--Issue an *organization* determination notice whenever a member requests reimbursement for emergency services or urgently needed out-of-area services.

2. **Reimbursement for Services Denied by the Plan that the Member Received Out-of-Plan.**--Issue an *organization* determination notice for health services received out-of-plan that the enrollee believes:

   - Are covered under Medicare; and
   - You should have furnished, arranged for, or reimbursed.

3. **Transferred Claims.**--Issue an *organization* determination notice on all claims transferred by carriers or intermediaries.

4. **Service Denials.**--Issue an *organization* determination notice if you refuse to provide services for which the enrollee believes you are responsible and the enrollee has not received the services out-of-plan. Make this written determination whenever any plan representative denies a service, whether it is a plan-contracted provider or a plan employee or official.

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

5. Advise physicians and other plan representatives that if they refuse to provide a service for a member, the member may appeal the decision. Educate plan physicians and representatives on beneficiary appeals rights, including how and when a member may file an appeal. If a physician denies an enrollee's request for a service, he/she should ask the enrollee if he/she would like to appeal. The plan must issue a written determination to the member whenever the member disagrees with the physician's decision or wants to appeal a service denial.

6. ***Organization* Determinations for Supplemental Benefits.**--The Medicare appeal procedures apply to services included in an optional supplemental benefit package, *as well as* all benefits offered in risk-based plans' basic Medicare package, whether these benefits are funded through Medicare payments or through member premiums. The appeal procedures also apply to Part A benefits (inpatient hospital and skilled nursing facility services) for which "Part B only" Medicare beneficiaries pay a premium.

7. ***Organization* Determination Concerning Enrollee Rights Regarding Medicare Covered Services You Have Furnished.**--Issue an *organization* determination notice when you deny rights claimed by an enrollee regarding Medicare covered services you furnished, if the denial produces a dispute with an identifiable dollar value.

2403.3 Processing Guidelines for *Organization* Determinations with Incomplete Documentation.--If documentation of a request for service is incomplete, try to obtain all relevant documentation within the *14* day *or 72 hour expedited* deadline. *You may extend the timeframe by up to 14 days if the enrollee requests the extension or if you justify a need for additional information and explain how the delay is in the interest of the enrollee, (e.g. diagnostic test). The extension is not permitted in order to obtain medical records from network providers. When waiting for medical records from a non-network provider the time doesn't begin until the records are received. Document the case file as to when the records were requested.* If you cannot obtain relevant documentation before the deadline, make the best decision possible based on the available information. Do not automatically deny the claim due to lack of medical documentation. If the only information available is the beneficiary's description of the situation, base the decision on that description. If you receive further information after making your decision, you may reopen it as described in Section 2409.

2403.4 Notice of *Organization* Determination. *2403.4 is outdated and replaced here by 42 CFR 422.568.*

Figure 2-20-N-10 Appeals *(This figure has been updated to reflect M+C requirements)* (Continued)

(a). Timeframes for requests for service. *When a party has made a request for a service, the M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization received the request for a standard organization determination. The M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justified a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.*

(b). Timeframes for requests of payment. *The M+C organization must process requests for payment according to the "prompt payment" provisions set forth in Section 422.520.*

(c). Written notification for adverse organization denials. *If an M+C organization decides to deny service or payment in whole or part, it must give the enrollee written notice of the determination.*

(d). Content of the notice. *The notice of any denial under paragraph (c) of this section must -*

(1) State the specific reasons for the denial in understandable language;

(2) Inform the enrollee of his or her right to a reconsideration;

(3) Describe both the standard and expedited reconsideration processes, including the enrollee's right to and conditions for obtaining an expedited reconsideration for service requests, and the rest of the appeal process; and

(4) Comply with any other requirements specified by HCFA

DO NOT USE-We have denied your out-of-plan service because it was not emergency care, out-of-area urgently needed care, or authorized by a plan representative

(e). Effect of failure to provide timely notice. *If the M+C organization fails to provide the enrollee with timely notice of an organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.*

2403.5 Effect of the *Organization* Determination.--The *organization* determination is final and binding on all parties unless it is reconsidered or revised under HMO Manual Section 2409

HMO 2409. REOPENING DETERMINATIONS AND DECISIONS

The entity which makes an *organization*, reconsidered, or revised determination may reopen the determination.